

CONSENT FOR GYNECOMASTIA SURGERY

Patient Name: _____

Age / Sex: _____

Date: _____

Address: _____

1. Nature of Procedure

I understand that Gynecomastia Surgery is performed to reduce enlarged male breast tissue and improve chest contour. The procedure may include:

- Liposuction
- Gland excision
- Combination of both techniques
- (as described on page 3 of the document)

2. Pre-operative Evaluation

I agree to undergo necessary investigations including:

- Blood tests (CBC, BT, CT, PT, APTT)
- Blood sugar, renal function tests
- Viral markers (HIV, HCV, HBsAg)
- ECG and other required tests
- Endocrinology evaluation if needed
- (as listed on pages 1–2)

3. Anaesthesia

I understand that the procedure may be done under:

- General Anaesthesia
- Or Sedation with Local Anaesthesia
- (page 2)

4. Procedure Details

I understand that:

- Surgery duration is approximately 1.5 to 3 hours
- Liposuction and/or gland removal will be performed
- Drain tubes may be placed temporarily
- It may be a day care procedure or require short hospital stay
- (page 3)

5. Risks and Complications

Common Risks

- Pain, swelling, bruising
- Infection
- Bleeding
- Fluid collection (seroma)
- Scarring
- Temporary numbness

Specific Risks (page 4)

- Asymmetry
- Skin irregularities
- Fat necrosis
- Skin discoloration
- Delayed wound healing
- Tissue loss (rare)
- Need for revision surgery

6. Post-operative Care

I understand that:

- Compression garment must be worn for 4–6 weeks
- Drains (if placed) are removed within 24–48 hours
- Physical activity restrictions apply
- Follow-up visits are necessary
- (page 3)

7. Recovery

- Initial recovery: about 1 week
- Return to normal activities: 2–3 weeks
- Final results take time to stabilize

8. Alternatives

- I understand that non-surgical options or no treatment have been explained.

9. Consent Statement

I confirm that:

- The procedure, risks, benefits, and alternatives have been explained clearly
- I have had the opportunity to ask questions
- I understand that results may vary
- I voluntarily consent to undergo Gynecomastia Surgery

Signatures

Patient / Attender Signature: _____

Doctor's Signature: _____

Date: _____

Place: _____

SHIVANI MEDICAL CENTER